APPENDIX B

Integrated work in Sutton to Date

The Joint Strategy for Health and Social Care in Sutton (2014)
This strategy was developed as part of the first Sutton Better Care Fund plan submission and includes a vision for integrated health and social care in Sutton:
'*We all share a common purpose to put people at the centre enabling them to stay healthier at home for longer by doing more to prevent ill-health, supporting people to manage their own health and well-being and providing more services in people's homes and communities'.*
The strategy goes on to say:
'The co-commissioning efforts will be reinforced by strengthening organisational relationships and a pooled budget, enabled by the Better Care Fund'.

Integration Projects

Sutton Integrated Digital Care Record - Launched January 2016

The Sutton Integrated Digital Care Record (Sutton IDCR) is an innovative secure electronic record that brings together health and social care information for patients registered with a Sutton GP. Having access to important information about a patient's allergies, existing medical conditions and the medicines they are taking will help doctors at Epsom and St Helier Hospitals (for example in the Emergency Department) provide the best care and advice possible. Clinicians will have instant access to information that will save treatment time and reduce time spent requesting information from health providers. Patients will receive smarter and more effective support which will prevent unnecessary hospital admissions

Sutton Vanguard

Sutton Clinical Commissioning Group (SCCG) was awarded Vanguard status in March 2015 – one of only six enhanced health in care home vanguards in England.

The vanguard programme aims to improve the health and quality of life for all care home residents in Sutton by delivering a new care model that offers older people living in care homes improved and integrated health care and rehabilitation services.

The SCCG are working in partnership with local health and social care providers including The London Borough of Sutton, Age UK Sutton and The Alzheimer's Society across the Sutton registered GP population of 191,000 and 25 GP Practices

Short Term Assessment and Reablement Team (START)

START is a multi disciplinary team consisting of professionals from both adult social services and the NHS including support workers, social workers, occupational therapists and physiotherapists. The START team provides a flexible short-term care and reablement service, assisting people to maximise their level of individual ability and independence within their own homes.

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The Community In-reach Team (SWOOP)
The Community In-reach Team is a dedicated multidisciplinary team that has been formed to improve the patient pathway from the hospital back into the community and support capacity management at St Helier's. This will be achieved by the team undertaking all non-simple discharge assessments, to inform the appropriate discharge destination with the patient. Expediting their discharge from St Helier hospital back into the community within the borough of Sutton. Liaising with acute services to ensure that all diagnostic and treatments are completed and that referrals to appropriate services are made.

The aim is a whole systems approach to the management of unplanned care, with all services working together, to ensure individuals receive high quality care appropriate to their needs. This includes exploring opportunities for delivering care closer to home outside acute hospitals in an integrated way, building on partnerships which have been built up over time between Sutton Community Health Services, Adult Social Services and the Acute Trust.

Integrated Locality Teams
Integrated Locality Teams enable integrated working to improve efficiency including avoiding duplication; facilitating timely access to the right services at the right time and effective informed commissioning decisions.

Work is underway to establish three Integrated Locality Hubs, Wallington, Carshalton and Sutton/Cheam. Our initial focus is the Wallington locality with the plan to co-locate staff from both health and adult social care services in October 2017. These moves should facilitate and promote ongoing work towards joint assessment; care planning and the use of multi-disciplinary team meetings. Running in parallel to the capital works is an organisational development programme to design an integrated model with front line staff, including Community Health Services, Adult Social Services, Encompass (brokerage), home care providers and voluntary sector organisations to ensure all opportunities for integration through co-location are realised and provide efficiencies through enhanced joined-up working.

Local Government Association Integration Toolkit
Working in partnership with the Local Government Association, NHS Confederation and ADASS, an integration self-assessment tool kit has been developed to help local health and care leaders move further and faster on achieving their vision of integration.
It will enable local areas to assess their own readiness to bring about integration, and identify what action they need to take.

Sutton is a pilot site for this integration self-assessment toolkit.